Harrison County Hospital
Referral for Diabetes Self-Management Education/Training (DSME/T)
***Indicates required information for Medicare.**
Fax completed and signed form to HCH Cardiology Fax: (812) 738-7823

Diabetes Self-Management Training - First Tuesday of every month
At Harrison County Hospital from 9 am – 2 pm - For more Information call: (812) 738-7887

Patient's name:___________________________**DOB:**__________________**SSN:**______________________

Home phone: ______________________**Work phone:** __________________**Cell phone:**________________

Address:____

Insurance company:____ **Policy ID #:**_____________________

Precert required: yes or no /referral #:____

Appointment date:____________________**Arrival time:**__8:30 am__**Appointment time:**___9:00 am_______

*DIAGNOSIS

☐ Type 2 controlled (E11.9)
☐ Type 2 uncontrolled, hypoglycemia (E11.649)
☐ Type 2 uncontrolled, hyperglycemia (E11.65)
☐ Type 1 controlled (E10.9)
☐ Type 1 uncontrolled, hypoglycemia (E10.649)
☐ Type 1 uncontrolled, hyperglycemia (E10.65)
☐ Other (describe)____

***Does this patient have conditions/barriers that make it difficult to participate in group education? Check and describe all that apply.**____

☐Impaired vision ☐Impaired hearing ☐Impaired cognition ☐Physical impairment ☐Language barrier

Please describe specific conditions____

*Education/Training Ordered (G0109)

Diabetes Self-Management Education/Training (DSME/T) and Medical Nutrition Therapy (MNT) are individual and complementary services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSME/T improve outcomes. (Medicare allows an initial 10 hours of group DSMT in a 12 month period, plus 2 hours of follow-up DSMT yearly)

***Check type of services and number of hours requested.**

☐ Initial Group DSME/T for 10 hours/year (or indicate number of hours if less than 10 hours is needed_____)
☐ Follow-up DSME/T for 2 hours/year (or indicate number of hours if less than 2 hours is needed_____)

***Check specific diabetes teaching needed:**

☐ **All content areas or as listed below**

☐ Disease process ☐ Healthy eating ☐ Being active ☐ Monitoring
☐ Taking Medications ☐ Healthy Coping ☐ Reducing Risks ☐ Problem Solving

☐ **Insulin teaching (or other injectable diabetes medication). Please list type and amount:**_________________________

*Documentation

Please send recent blood glucose and A1c values for insurance eligibility and outcomes monitoring.
Medications:____
____

☐ Hemoglobin A1C lab blood draw 90 days after attending class

*Physician's signature (required):_______________________________________ Date: _____________

Physician name (print):______________________________________Office phone: _______________

Practice name: ____Office fax: __________________